Performance

Report

**1800 951 822**

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| Name of service: | St Joseph's House |
| Service address: | 22 Norman Street PORT PIRIE SA 5540 |
| Commission ID: | 6961 |
| Approved provider: | The Catholic Diocese of Port Pirie Inc |
| Activity type: | Site Audit |
| Activity date: | 14 March 2023 to 17 March 2023 |
| Performance report date: | 17 May 2023 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for St Joseph's House (**the service**) has been prepared by M Glenn, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies any areas in which improvements must be made to ensure the Quality Standards are complied with.

# Material relied on

The following information has been considered in preparing the performance report:

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representative, staff, management and others;
* the provider’s response to the Assessment Team’s report received 21 April 2023; and
* a Performance Report dated 23 December 2022 for an Assessment Contact – Site undertaken on 16 November 2022.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

Areas have been identified in which improvements must be made to ensure compliance with the Quality Standards. This is based on non-compliance with the Quality Standards as described in this performance report.

**Standard 2 requirement (3)(e)**

* Ensure staff have the skills and knowledge to initiate assessments and update care plans in response to consumers’ changing condition, care and service needs.
* Ensure care plan review processes, are undertaken in line with the service’s processes and include a detailed review of consumers’ care and services over the previous month.
* Ensure care plans are reflective of consumers’ current and assessed needs and preferences to enable staff to provide quality care and services.
* Ensure policies and procedures in relation to assessment, care planning and review are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to assessment, care planning and review.

**Standard 3 requirements (3)(a), (3)(b), (3)(d), (3)(e) and (3)(g)**

* Ensure staff have the skills and knowledge to:
  + provide appropriate care relating to skin integrity, pain and wound management;
  + initiate appropriate assessments, develop management plans and monitor effectiveness of management plans, including in relation to wounds and pain;
* identify deterioration or change of consumers’ condition, implement appropriate monitoring processes and review care and service management strategies to ensure care provided is reflective of consumers’ changed condition;
* ensure Medical officers record and communicate instructions or recommendations following consumer review, including change of treatment;
* initiate timely and appropriate referrals to Medical officers and/or appropriate Allied health professionals in response to changes in consumers’ condition; and
* implement processes and practices to minimise infection related risks and promote appropriate antibiotic prescribing.
* Review information exchange processes to ensure sufficient, relevant and up-to-date information is provided to staff to enable appropriate delivery of care and services to consumers.
* Ensure the Infection register is maintained to enable effective monitoring of infection rates and antibiotic use and opportunities to minimise infection related risks to be identified.
* Ensure policies, procedures and guidelines in relation to management high impact or high prevalence clinical risks, wounds, pain, skin integrity and infection control are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to management high impact or high prevalence clinical risks, wounds, pain, skin integrity and infection control.

**Standard 7 requirements (3)(c), (3)(d) and (3)(e)**

* Ensure staff competency, skills and knowledge are monitored and tested to ensure staff are competent to undertake their roles.
* Ensure staff are provided appropriate training to address the deficiencies identified in four of the eight Quality Standards.
* Ensure regular assessment, monitoring and review of the performance of each staff member is undertaken and where poor staff performance is identified, ensure performance management processes are implemented promptly.

**Standard 8 requirements (3)(b), (3)(c), (3)(d) and (3)(e)**

* Ensure the governing body is aware of and accountable for the delivery of care and services through review of communication and reporting processes from the service to the Board and vice versa.
* Review the organisation’s governance systems in relation to information management, continuous improvement and workforce governance.
* Review the organisation’s risk management processes in relation to managing high impact or high prevalence risks, responding to abuse and neglect and managing and preventing incidents.
* Review the organisation’s clinical governance framework in relation to antimicrobial stewardship and monitoring of consumer infections, as well as in relation to the non-compliance identified in Standard 2 Ongoing assessment and planning with consumers and Standard 3 Personal care and clinical care.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

All consumers and representatives sampled said consumers are treated with dignity and respect and their identity and diversity is valued. Assessment processes assist to identify consumers’ likes and dislikes, and care files sampled were reflective of consumers’ background. Staff sampled were familiar with consumers’ backgrounds, needs and preferences, and were observed treating consumers respectfully and in a dignified manner when providing care.

Consumers felt valued and safe when receiving care and services, said their culture is respected, and they are supported to maintain their identity. Consultation and assessment processes identify how consumers wish to be supported to maintain their culture, beliefs and traditions, and care files sampled identified consumers’ backgrounds and strategies to support them. Policy and procedure documents outline how staff can support consumers to ensure cultural safety is maintained and staff were familiar with consumers’ specific cultural needs and described how they tailor care and services to meet those needs.

Consumers felt the service supports them to make decisions about their own care and representatives said they are involved in decisions about care and services when consumers are unable to communicate those decisions themselves. Care files included involvement of representatives, and staff gave examples of how they assist consumers make day-to-day choices and to access support consumers need.

Consumers said they are supported to take risks which enables them to be independent and staff described how they support consumers to take risks. Where consumers are identified as partaking in an activity which includes an element of risk, Dignity of risk forms are completed in consultation with the consumer, which includes discussion relating to related risks and implementation of agreed upon strategies to mitigate risks. Allied health specialists are involved in assessment processes, as required.

Information is provided to consumers through a range of avenues, including emails, noticeboards, newsletters and consumer meeting forums. Consumers were happy with information communicated to them and said staff were very good at communicating information. There are processes to ensure consumers’ privacy is respected and personal information kept confidential. Consumer and employee handbooks include reference to consumers’ right to privacy and dignity and the importance of consumers’ personal information remaining confidential.

For the reasons detailed above, I find all requirements in Standard 1 Consumer dignity and choice compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Non-compliant |

Findings

The Quality Standard is assessed as non-compliant as one of the five specific requirements has been assessed as non-compliant. The Assessment Team recommended requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers not met.

**Requirement (3)(e)**

The Assessment Team were not satisfied care plans are consistently reviewed for effectiveness when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Through Resident of the day processes, clinical staff are to review progress notes for the month, report vital signs outside the consumer’s reportable range and review the consumer’s picture care plan and liaise with the Registered nurse and/or Clinical nurse consultant to adjust the care plan.
* Consumer A’s February 2023 Resident of the day review stated the consumer had no infections and did not note a urine specimen had been sent for pathology or if results had been followed up.
* Consumer B’s Resident of the day review did not include a review of wounds. Care plans and assessments did not include changes to mobility resulting from pressure wounds. Care staff confirmed changes in the consumer’s mobility needs. Additionally, shower charting indicated Consumer B is provided personal hygiene in the afternoons; this preference was not noted in the care plan.
* Staff stated assessments and care plans are reviewed and updated through the reassessment process and changes are made when consumers’ need change. However, staff indicated some information is captured within numerous assessments and sometimes it is updated in one assessment but not correct in other assessments.

In coming to my finding for this requirement, I have also considered evidence highlighted in a Consumer outcome summary for Consumer B, and the provider’s response, specifically:

* When asked if they had pain, the consumer said yes, indicating they had pain in the lower limbs associated with pressure wounds.
* The last Pain assessment dated January 2023 only refers to pain in the knee. Wounds were not captured or interventions documented.
* Daily massages are documented through pain charting, however, a pain score prior to treatment is not captured and pain is noted to be located all over body. Pain during wound treatments is not captured.
* The last Skin assessment dated January 2023 states repositioning is to occur two-hourly during the day and four-hourly overnight. Progress notes dated November 2022 state strict two-hourly repositioning.

The provider’s response included commentary relating to the deficits identified by the Assessment Team, as well as supporting documentation and actions taken in response. The response also included a Training plan, as well as a Plan for continuous improvement (PCI) outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* A General practitioner referral fax form dated 15 February 2023 for Consumer A which includes a notation dated 26 February 2023 indicating two samples had been sent for pathology and results were pending. Commentary included in the provider’s response indicates the urine pathology was negative.
* Consumer B commenced on an end of life pathway subsequent to the Site Audit, which includes management of pain. The provider indicates discussions held by the Assessment Team with Consumer B are in doubt due to difficulties the consumer has communicating with people who are strangers to them.
* A Pain assessment/management plan dated January 2023 indicating location of pain as the knee and to ensure at least four times a day repositioning.
* Resident of the day progress note entries for January 2023 indicating narcotic analgesic had been prescribed for pain; and February 2023 indicating the representative was concerned about pain relief, was notified of narcotic analgesic prescribed and the Medical officer to be contacted regarding increasing medication to cover pain. Reviews for January, February and March 2023 referenced pressure wounds to varying degrees.
* A Care evaluation-care outcomes/changes document dated March 2023 referencing the consumer’s preference for afternoon hygiene care, commencement of narcotic analgesic (location of the pain is not noted) and current mobility requirements.
* Reviewed the Resident of the day flowchart and provided education to staff.
* Training related to documentation/care planning is planned to be completed by September 2023.

I acknowledge the provider’s response. However, I find the service did not ensure care and services were effectively reviewed in response to incidents and changes in consumers’ care and service needs.

In coming to my finding, I have considered Resident of the day processes did not include a detailed summary or review of consumers’ health and/or condition over the previous month, or evidence review of care plan documentation, in line with the service’s processes. Resident of the day reviews sampled did not effectively identify changes in Consumer A or B’s condition or inconsistencies in assessment and care plan documentation. While evidence presented by the Assessment Team and included in the provider’s response indicated Consumer A had specimens sent to pathology, a Resident of the day review did not indicate the outcome of pathology, or if it was pending, or reference the consumer’s condition. In relation to Consumer B, while I acknowledge Resident of the day reviews referenced wound management, the review process had not identified that information in assessments, charting and care planning was not congruent with the consumer’s current condition, needs or preferences, relating to hygiene and mobility.

I have also considered Consumer B’s pain was not effectively monitored or management strategies implemented. Pain charting did not reference pain levels prior to and after massage treatments, nor consider pain related to pressure wounds. Additionally, pain assessments did not reference pressure wounds or related pain, with the last assessment dated January 2023. The consumer indicated they were experiencing pain in the lower limbs, and Resident of the day reviews for January and February 2023 included in the provider’s response indicated narcotic analgesia was commenced for pain management and concerns voiced by the representative relating to pain relief. There is no indication pain has been assessed, pain management strategies reviewed or new strategies implemented in response to the addition of narcotic analgesia or pressure wound deterioration.

I acknowledge staff sampled were knowledgeable of Consumer B’s current mobility, repositioning and hygiene requirements, however, I find the inconsistencies in assessment and planning have the potential to impact on the effective delivery of care and services, particularly where staff delivering care are not familiar with consumers or their care and service needs.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/or implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish efficacy, staff competency and improved consumer outcomes.

For the reasons detailed above, I find requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

**In relation to all other requirements**

Requirement (3)(a) was found non-compliant following an Assessment Contact – Site undertaken on the 16 November 2022 where it was found assessment and planning, specifically in relation to wound management, blood pressure monitoring and depressive symptoms, was not effectively undertaken to ensure assessment and planning was tailored and reflective of consumers’ current needs. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Completed Dignity of risk consultation forms for consumers who wish to undertake risky activities.
* Placed a pressure injury identification guide for quick reference on the wound trolley to assist nurses in identification and documentation of wounds.
* Reviewed Local work instructions for Resident of the day, wound care, falls prevention and management, skin management care plan and pressure injury prevention and management, and created work instructions for mental health, South Australia virtual care services, dignity and risk and duty of care.
* Made a request for Medical officers to provide reportable ranges for blood pressure, diabetes and vital observations for consumers on entry, and completed a template to be sent to Medical officers to complete and send back to the service with consumers’ reportable ranges.
* Provided education to staff on pressure injuries, positioning and repositioning, skin tears, recognising changes in a consumer's condition and wound assessment and management.

The Assessment Team’s report provided the following evidence gathered through interviews, observations and documentation relevant to my finding:

Care files sampled demonstrated a range of assessments which consider personal, clinical and lifestyle aspects of care are completed on entry and on an ongoing basis. A range of risk assessment tools are also used to inform care planning. Information gathered from consultation with consumers and/or representatives and assessment processes is used to develop a care plan which incorporates each consumer’s needs, preferences, goals and strategies to manage identified risks. Charting is used to monitor specific care needs, such as pain, continence, sleep and behaviours, and evaluation of outcomes is used to inform the assessment and planning process. Consumers and representatives indicated the entry process had been comprehensive and staff had a good understanding of consumers’ care needs and preferences.

Consumers and representatives confirmed assessment and planning identifies and addresses consumers’ current needs, goals and preferences. Assessments included detailed individualised strategies and advance care planning, goals, needs and preferences, and care files demonstrated conversations with consumers in relation to advance care and end of life planning occur on entry, during regular care evaluation processes and as required. Policies and procedures are available to guide staff in delivery of care at the end of life phase, and care and clinical staff were aware of where to access information relating to consumers’ end of life directives.

Care files sampled confirmed consumers and their representatives are involved in assessments and planning of care and services on entry and on an ongoing basis and demonstrated involvement of Medical officers and Allied health specialists in consumers’ care. Consumers and representatives described occasions where they had been consulted in relation to assessments, reviews and changes to consumers’ care and service needs following Medical officer and Allied health visits and felt they were very well informed of any changes or reviews of consumers’ care and service needs.

There are processes to ensure the outcomes of assessment and planning are communicated to consumers, staff and others and documented in a care plan which is readily available to staff to guide provision of care and services and to consumers on request. Care plans included detailed information and individualised strategies relating to each consumer’s goals, needs and preferences for personal, clinical and lifestyle aspects of care. Most consumers and representatives confirmed they are kept informed of any changes, incidents or updates to assessments and felt engaged in the care and services provided. Representatives were aware of care plan documents and confirmed they were able to access the care plan if they wished.

For the reasons detailed above, I find requirements (3)(a), (3)(b), (3)(c) and (3)(d) in Standard 2 Ongoing assessment and planning with consumers compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Non-compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Non-compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Non-compliant |

Findings

The Quality Standard is assessed as non-compliant as five of the seven specific requirements have been assessed as non-compliant. The Assessment Team recommended requirements (3)(a), (3)(b), (3)(d), (3)(e) and (3)(g) in Standard 3 Personal care and clinical care not met.

**Requirement (3)(a)**

The Assessment Team were not satisfied each consumer receives safe and effective personal and clinical care that is best practice and tailored to their needs, specifically in relation to management of infections and catheter care. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* A urine specimen collected for Consumer A on entry identified blood and leukocytes. Progress notes indicated Consumer A demonstrated some confusion, however, they were in a new environment and has a cognitive impairment.
* A review by the Medical officer occurred a week later where an additional urine sample was requested to be collected and tested internally. The sample showed the same results initially identified and documentation stated the results were emailed to the Medical officer. No additional information was captured regarding a urine infection until eight days later where the Medical officer requested bloods and a urine sample to be sent for pathology.
* The service was contacted by the pathology service on the same day requesting an additional two samples be collected on two consecutive days for testing. Both samples were collected and awaiting collection, however, were not received by the pathology service until three days later.
* Consumer A was reviewed by the Medical officer a week following collection of the samples to discuss blood results. There was no mention of a urine infection or treatment. No further information was captured relating to a urine infection up until the Site Audit.
* A representative stated Consumer C’s catheter was due to be changed, however, this had not been done and it was starting to hurt them. The representative confirmed they had informed staff, however, the consumer was still waiting to see the Medical officer. The catheter was changed during the Site Audit, five days later than scheduled.

The provider’s response included commentary relating to the deficits identified by the Assessment Team, as well as supporting documentation and actions taken in response. The response also included a Training plan, as well as a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* In relation to Consumer A, the provider’s response indicates urine pathology was negative.
* Consumer C’s catheter is changed by the Medical officer three monthly, in line with the care plan. The Medical officer was contacted prior to the due date, but had been unable to attend until three days post the change due date. Consumer C had been assessed as not requiring urgent attention as there had been no signs of discomfort, pain, drainage related issues, swelling or redness.
* Reviewed policy documents to include early intervention to any discomfort related to Consumer C’s catheter and actions to take if the Medical officer is unable to attend prior to the change due date. This was reflected in an Acute care needs/nursing care plan provided.
* Training related to urinalysis is planned for completion by April 2023 and detecting and managing urinary tract infections by August 2023.
* Created a Urinary tract management Local work instruction which includes flowcharts for assessment and action.

I acknowledge the provider’s response. However, I find safe and effective personal and/or clinical care that was tailored and optimised health and well-being was not provided, specifically to Consumer C.

While the provider asserts Consumer C had been assessed as not requiring urgent attention as there had been no signs of discomfort, pain, drainage related issues, swelling or redness related to the delay in changing the catheter, this assertion is not supported by documents included in the provider’s response. A Pain assessment/management chart for the day prior and day of the catheter change evidence that the consumer complained of pain associated with the catheter and general abdominal pain on four occasions requiring administration of analgesia. Progress notes for the same dates also indicate the consumer was experiencing discomfort related to the catheter and a notation the day prior to the catheter change outlines a discussion with the consumer and representatives relating to the delay in the catheter change, indicating the consumer ‘remains uncomfortable, with an urge to pass urine’. There is no catheter related pain noted in the pain chart in the 27 days post the catheter change. As such, I find the evidence presented does not demonstrate Consumer C’s health and well-being were optimised.

In relation to Consumer A, while I acknowledge urine specimen results were not followed up in a timely manner, there is no indication this impacted the consumer’s health and well-being. The Assessment Team’s report states the consumer demonstrated some confusion on entry to the service, however, it is acknowledge the consumer had a cognitive impairment and was new to the environment. There is no further evidence provided to indicate changes to the consumer’s health and well-being occurred which could be indicative of a urinary infection.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish efficacy, staff competency and improved consumer outcomes.

For the reasons detailed above, I find requirement (3)(a) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(b)**

The Assessment Team were not satisfied skin integrity and wounds are effectively monitored or managed, resulting in wounds being acquired at the service and wound deterioration. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Daily clinical handover sheets are used to review high risk consumers, however, did not demonstrate interventions commenced to effectively manage changes to consumers’ health, including infections, for example:
* A notation in February 2023 indicates Consumers D and E commenced on antibiotics. There is no additional information included as to why antibiotics were commenced and if they required additional strategies to manage their infections.

Consumer B

* Wound 1 was identified in September 2022 as a stage 4 unstageable pressure wound. The wound had not been identified prior. Progress notes between November 2022 to March 2023 shows the wound has deteriorated and has been infected since November 2022.
* A wound swab was completed in February 2023, although antibiotics were commenced the day prior.
* Progress notes and wound charting did not consistently capture information regarding wound presentation. Wound photographs were taken at different angles with the ruler placed in various positions making it difficult to assess the size. Photographs show the wound was wet leaving the surrounding skin macerated.
* Wound 2 was identified in October 2022 as an abrasion. Photographs show the wound increased in size in January 2023, with the wound showing blackened areas and redness/bruising going up the leg. Documentation does not demonstrate the Medical officer was informed about the increasing size of the wound or that the wound was reviewed by an external specialist to assist in wound management.
* Medication charts show antibiotics have been commenced on seven occasions between October 2022 and February 2023, however, wound swabs did not occur when antibiotics were commenced.
* Consumer B indicated they had pain associated with the wounds which was confirmed by staff. Staff indicated the consumer expresses pain when moved and that they yell or grimace a lot.
* Pain during wound care was noted throughout progress notes. A narcotic analgesic was increased in February 2023 for increased pain, although the consumer had been experiencing pain since November 2022. The last Pain assessment was dated January 2023 and only refers to knee pain. Pain relating to wounds was not captured or interventions noted.

The provider’s response included commentary relating to the deficits identified by the Assessment Team, as well as supporting documentation and actions taken in response. The response also included a Training plan, as well as a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* Updated processes to encourage use of virtual/telehealth services for wound reviews when the Medical officer does not attend the service in a timely manner.
* Created a training plan, inclusive of pressure area care, documentation, wound management and skin integrity.
* Wound/skin integrity management plans and evaluation for wounds 1 and 2.

In coming to my finding, I have considered that this requirement expects that services effectively manage high impact or high prevalence risks associated with the care of each consumer. That is, each individual consumer should expect to have high impact or high prevalence risks associated with their care effectively managed. Based on the Assessment Team’s report, I find this did not occur for Consumer B, specifically in relation to management of wounds and pain.

I have considered staff practices have not ensured changes to skin integrity are identified in a timely manner, wounds effectively monitored and assessed to enable wound progression to be tracked or that wound deterioration is effectively identified and actioned. Wound 1 was not identified until it was a stage 4-unstagable pressure injury, at which time it was described as broken with a large necrotic area, demonstrating the consumer’s skin integrity was not effectively monitored. Wound presentation was not consistently captured following wound treatments and photographs were found to not be a reliable source of reference. In relation to wound 2, advice was not sought from the Medical officer or external specialist services where a deterioration in the presentation of the wound, which was described as having blackened areas and redness/bruising going up the leg, was identified. Considering the nature of the wounds described, there should be an expectation that wounds are monitored at each treatment, including consideration of wound appearance. Such practices would ensure wound progression is monitored, wound deterioration is identified in a timely manner and actions taken accordingly.

I have also considered Consumer B’s pain relating to pressure wounds has not been effectively managed. The provider’s response places doubt on the discussions the Assessment Team had with Consumer B due to the consumer’s difficulties with communicating with people who are strangers, however, I have placed weight on feedback provided by Consumer B indicating they had pain associated with wounds. This was supported by staff who stated the consumer expresses pain on movement, including though yelling and grimacing. I acknowledge a narcotic analgesic was increased in February 2023, however, despite progress notes indicating the consumer had been experiencing pain since November 2022, the last pain assessment completed in January 2023 did not reference pain related to pressure wounds. As such, I find appropriate assessment and development of strategies to manage the consumer’s pain has not been undertaken to ensure comfort is maintained.

In relation to wound swabs and commencement of antibiotics for Consumer B, I consider the evidence relates to management of infections and appropriate use of antibiotics. As such, I find the evidence is more aligned with requirement (3)(g) in this Standard and have considered it with my finding for that requirement.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish efficacy, staff competency and improved consumer outcomes.

In relation to wound swabs and commencement of antibiotics for Consumer B, and evidence relating to Consumers D and E, I consider the evidence relates to management of infections and appropriate use of antibiotics. As such, I find the evidence is more aligned with requirement (3)(g) in this Standard and have considered it with my finding for that requirement.

For the reasons detailed, I find Requirement (3)(b) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(d)**

The Assessment Team were not satisfied deterioration or change in consumers’ mental health, or physical function is recognised and responded to in a timely manner. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Consumer F was last reviewed by a Dietitian in December 2022, who recommended a further referral, including if weight fell below 50kg. Progress notes indicate in March 2023, the consumer recorded a 3.4kg weight loss since January 2023. The Medical officer was notified in March 2023 of Consumer F’s weight loss over the six month period.
* A Nutrition risk screening assessment dated February 2022 identifies the consumer as moderate risk. No additional risk screening has been completed in relation the weight loss over the six-month period.
* Progress notes between January to February 2023 show staff were monitoring and recording Consumer F’s weight weekly, however, note the consumer declined, becoming sleepier and lethargic.
* A progress note in February 2023 indicated the consumer was lethargic and falling asleep during activities and the Medical officer notified. Actions taken or additional monitoring of the consumer was not documented. Additional progress notes show on another five occasions the consumer was struggling to stay awake and was disorientated and lethargic.
* The consumer was reviewed by the Medical officer in March 2023, 27 days later, at which time medications were prescribed and blood tests ordered. Medications were subsequently ceased seven days later. Progress notes did not evidence blood test results or if any other investigations into the consumer’s change in condition at the time of the Site Audit.

The provider’s response included commentary relating to the deficits identified by the Assessment Team, as well as supporting documentation and actions taken in response. The response also included a Training plan, as well as a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* A nutrition assessment dated December 2022 which notes a 4.3kg weight loss from September to December 2022, a goal to not lose more than 2kg in a month and the outcome of a Speech pathology review conducted in September 2021. A referral to a Dietitian has been initiated for Consumer F.
* Created a training plan, inclusive of consumer deterioration, documentation and weight management.

I acknowledge the provider’s response. However, I find changes or deterioration in Consumer F’s condition were not effectively recognised or responded to in a timely manner. Despite Consumer F recording a weight loss in March 2023 of more than 2kg and falling below the ideal weight recommended by the Dietitian, a further referral, in line with the Dietitian’s December 2022 recommendations, was not initiated. Additionally, despite steady weight loss over a six-month period, further assessments have not been undertaken to identify the consumer’s risk of malnutrition or to determine if additional management strategies are required, in line with the consumer’s changing condition. I have also considered that despite a change in the consumer’s condition in February 2023, further assessment or monitoring of the consumer has not been undertaken. Furthermore, while the Medical officer was notified in February 2023 of a change in condition, review of the consumer did not occur until 27 days later. The consumer was still experiencing lethargy and disorientation at the time of the Site Audit.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvements activities planned and/implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish efficacy, staff competency and improved consumer outcomes.

For the reasons detailed above, I find Requirement (3)(d) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(e)**

The Assessment Team were not satisfied information about consumers’ condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Consumers and representatives stated there has been a large turnover of staff and a lack of staff to provide adequate care consistently to consumers. Representatives stated staff can be very busy and they do not get informed of incidents in a timely manner.
* One representative stated they used to ask staff to assist the consumer to ensure they got out of bed, however, this is still not occurring and when they ask care staff, staff state they have not been informed of this request.
* Clinical and care staff stated:
* when they have time off, they are not informed of changes to consumers that have occurred, and need to find time to review all the progress notes to identify what has occurred;
* they do not receive handover for the consumers, however, some staff choose to stay behind after their shift to provide staff on the next shift with information on what has occurred for the consumers within that area; and
* they do not have any meetings, therefore, are not always informed about things occurring within the service.
* Management stated the Medical officer does not communicate with staff and will often not attend the service to review consumers. The Medical officer does not normally document in consumers’ progress notes, or if they do it is under whichever staff members’ name that is logged into the computer system at the time.

The provider’s response included a Training plan and a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified, supporting documentation. The provider’s response included, but was not limited to:

* Reminders to care staff of documented handover tools to ensure consistency of care.
* Care staff meeting held with additional meetings added to the meeting schedule.
* Medical officer log-in details reissued and Registered nurses given access to the electronic system to enable Medical officer passwords to be reset, if required.
* Updated the clinical handover tool and reviewed and updated Local work instructions, including in relation to handover processes. Training related to handover processes is planned for completion by May 2023.

I acknowledge the provider’s response. However, I find information about consumers’ condition, needs and preferences is not effectively communicated. In coming to my finding, I have placed weight on feedback from staff indicating they do not receive a handover from shift to shift, nor do they feel informed about what is happening at the service as staff meetings are not held. Consumers and representatives sampled also felt information exchange processes had been affected by staff turnover resulting in inconsistencies in provision of consumers’ care and timely notification of incidents. Additionally, I have also considered feedback from management demonstrating information exchange processes between the service and Medical officer are not sufficient. As such, I have considered that these practices do not ensure the workforce has sufficient information to enable coordination and delivery of safe and effective clinical care or have sufficient understanding of consumers’ conditions to provide and coordinate care.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish efficacy, staff competency and improved consumer outcomes.

For the reasons detailed above, I find Requirement (3)(e) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(g)**

The Assessment Team were not satisfied consumers’ infections are monitored and reviewed. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Management stated all consumers prescribed antibiotics for infections are captured in the Infection register, however, this was not evidenced in documentation viewed.
* Clinical staff were not able to describe antimicrobial stewardship principles. They stated whilst they undertake a dipstick analysis when urine infections are suspected, they do not routinely undertake pathology when other infections are suspected. They indicated they inform the Medical officer, and it is at their discretion.

In coming to my finding for this requirement, I have also considered the following evidence, and provider’s response, highlighted in requirements (3)(a) and (3)(b) in this Standard:

* A notation in February 2023 indicates Consumers D and E commenced on antibiotics. There is no additional information included as to why antibiotics were commenced and if they required any additional strategies to manage their infections.
* Medication charts for Consumer B show antibiotics have been commenced on seven occasions between October 2022 and February 2023, however, wound swabs did not consistently occur when antibiotics were commenced. A wound swab was completed in February 2023, however, antibiotics were commenced the day prior.

The provider’s response included commentary relating to the deficits identified by the Assessment Team, as well as supporting documentation and actions taken in response. The response also included a Training plan, as well as a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* Provided training to staff in relation to management of urinary tract infections;.
* Created a Local work instruction and flow chart to provide better management of urinary infections, and added infection management and antimicrobial stewardship to the training schedule.
* Provided an Infection record dated March 2023 for Consumer D demonstrating the consumer was identified with an infection post the Site Audit and was being treated with antibiotics.
* An Infection record and progress notes dated February 2023 for Consumer E demonstrating reasons for commencement of antibiotics.
* An Infection record and progress notes dated October 2022 for Consumer B indicating antibiotics were commenced.

I acknowledge the provider’s response. However, I find staff practices did not effectively promote appropriate antibiotic use to reduce the risk of antimicrobial resistance. Consumer B has been prescribed antibiotics on seven occasions over a four month period without further investigative measures consistently initiated to determine the type and/or source of infection to support appropriate antibiotic use. Additionally, while Consumer D was noted to have commenced antibiotics in February 2023, documentation to demonstrate why the antibiotics were commenced or that strategies to minimise antibiotic use was not evident.

I have also considered that the service did not demonstrate that data is used to monitor infections and resolution rates and the effectiveness of the infection control and prevention program. While an Infection register is in place, all consumers prescribed antibiotics for infections are not logged. I find this does not enable effective monitoring and analysis of infection rates and antibiotic use to identify trends and opportunities to minimise infection related risks and reduce risk of increasing resistance to antibiotics.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish efficacy, staff competency and improved consumer outcomes.

For the reasons detailed, I find Requirement (3)(g) in Standard 3 Personal care and clinical care non-compliant.

**In relation to requirements (3)(c) and (3)(f),** staff described personal and clinical care provided to consumers during the end of life phase and said they have access to information relating to consumers’ advance care directives. A care file for a recently deceased consumer demonstrated the consumer was regularly monitored, including for pain, representatives were kept informed and actions were implemented to address the consumer’s spiritual needs. Progress notes demonstrated the consumer passed away with their family by their side, in line with their wishes outlined in the palliative care plan. Consumers and representatives said, and a sample of care files demonstrated, discussions relating to advance care directives are undertaken on entry or during care consultation processes. One representative confirmed they have discussed what care and wishes the consumer would like when they are at the end stage of life, including having family with them and to be pain free.

Care files demonstrated timely and appropriate referrals are generally initiated to individuals and other organisations when needed. Staff described a range of organisations/providers involved in consumers’ care, including Medical officers and Allied health services, and consumers and representatives confirmed regular input from the multidisciplinary team, when required.

For the reasons detailed above, I find requirements (3)(c) and (3)(f) in Standard 3 Personal care and clinical care compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Consumers said they receive safe and effective services and supports for daily living that meet their needs, goals and preferences and optimises their independence, health, well-being. Care files sampled demonstrated consumers are assessed and care plans reviewed on a regular basis to ensure services and supports continue to meet their needs, goals and preferences. Care and clinical staff sampled described how they support consumers to achieve their daily living needs, goals and preferences, including through promotion of independence with activities of daily living. Consumers indicated their cultural and spiritual practices are acknowledged and observed and they are supported to attend mass, as well as celebrate specific cultural religious days. Consumers were observed being provided emotional support by staff.

Care files and activity attendance records sampled, and feedback from consumers confirmed consumers are engaged in activities of interest, are supported to maintain personal relationships, and are able to participate in the community within and external to the service. Lifestyle staff described how they work with other organisations, advocates, community members or groups to assist consumers to follow their interests and social activities, and to continue their community connections. An activity program, developed and tailored to consumers’ interests, is maintained and is monitored and adjusted, as required, based on consumers’ feedback. Consumers said they felt connected and engaged in meaningful activities that are satisfying to them.

Information about consumers’ condition, needs and preferences is documented and communicated within the service and with others where responsibility is shared and, where required, there are processes to ensure appropriate and timely referrals are initiated. Staff described systems and processes used to ensure information is communicated to them and consumers and representatives were satisfied they are kept informed about consumers’ care and service delivery needs, and felt staff are aware of consumers’ preferences, supports and care needs.

All consumers sampled were satisfied with the quality, quantity and variety of the meals provided and indicated they enjoy the food and alternative options are available. Meals are prepared in line with a four-week rotating menu and meals were observed to be appetising and well received. There are processes to regularly review the menu, including through monthly consumer meeting forums, with recent changes noted to have been made to the menu ordering process in response to consumer feedback.

Equipment required to support delivery of services was observed to be safe, suitable, clean and well-maintained. Preventative and reactive maintenance processes ensure equipment is maintained and records sampled demonstrated maintenance issues are addressed in a timely manner. Care staff described how they maintain equipment following use and how they report maintenance issues.

For the reasons detailed above, I find all requirements in Standard 4 Services and supports for daily living compliant.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

The service environment was observed to be welcoming, spacious and easy to navigate, and included communal spaces and outdoor areas. Consumers were observed utilising communal spaces, engaging with visitors and other consumers. Consumers sampled described their ability to decorate, arrange and personalise their rooms with their own furniture, photographs and bedding, which was observed by the Assessment Team.

The service environment is safe, clean, and well maintained, with consumers able to move freely both indoors and outdoors. Cleaning and reactive and preventative maintenance processes ensure the environment, furniture, fittings and equipment is safe and well-maintained. Staff described how they report maintenance issues and hazards, in line with the service’s processes. Consumers confirmed they felt safe living at the service and were satisfied with cleaning and maintenance services. Overall, furniture, fittings and equipment were observed to be safe, clean, well maintained and suitable for consumers and consumers said they felt safe when staff used equipment, it was appropriate for their needs and maintenance staff are quick to respond to any issues.

For the reasons detailed above, I find all requirements in Standard 5 Organisation’s service environment compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Consumers, family, friends, carers and others are encouraged and supported to provide feedback and make complaints. Staff described how they gather feedback from consumers, including asking them about their satisfaction with services or providing them with feedback forms to complete. Consumers and representatives felt confident to speak with staff and management to raise issues and knew where to find feedback forms and suggestion boxes.

Consumers are provided with information about internal and external feedback and complaints mechanisms, advocacy and language services on entry and brochures relating to feedback processes were observed to be displayed on information boards throughout the service. Staff said they receive training in complaints processes and described how consumers with diverse needs are supported to access language services and alternate communication processes.

Policy and procedure documents are available to guide staff practice with regard to managing feedback and complaints. Documentation sampled demonstrated appropriate action is taken in response to complaints and open disclosure principles are applied in response to adverse events. Staff described actions taken in response to complaints, indicating they attempt to resolve issues immediately, or escalate them to clinical staff for resolution. Most consumers and representatives said they have very few complaints, however, when they raise issues they are followed up and actions taken.

The service demonstrated how feedback and complaints are reviewed and used to identify and drive continuous improvement. An electronic system is used to record and track complaints which are monitored and reviewed to identify opportunities for improvement.

For the reasons detailed above, I find all requirements in Standard 6 Feedback and complaints compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Non-compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Non-compliant |

Findings

The Quality Standard is assessed as non-compliant as three of the five specific requirements have been assessed as non-compliant. The Assessment Team recommended requirements (3)(c), (3)(d) and (3)(e) in Standard 7 Human resources not met.

**Requirement (3)(c)**

The Assessment Team were not satisfied the workforce is competent or have the qualifications and knowledge to effectively perform their roles. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Staff competency is monitored through daily review of progress notes, walkarounds by management and Registered nurse, initial and annual competency assessments and review of incidents and audits.
* Daily progress note reviews were not effective in highlighting deficits in staff practice related to omissions in clinical documentation, identifying deterioration, deficits in wound care, pain management and infection control.
* Although management said they spend a lot of time on the floor, this is done in an ad hoc way, and observations are not recorded.
* Staff were not competent in monitoring and responding to suspected urinary tract or wound related infections.
* Management acknowledged wound audits have not been undertaken and the current range of scheduled audits are predominantly focused on policy and do not include review of consumer files to ensure staff compliance with work instructions, precluding opportunities to identify deficits in knowledge and implementation of relevant training.
* Wound care is incorporated in the Assessment and care planning audit which was undertaken in October 2022 and includes positive responses.

The provider’s response included commentary relating to the deficits identified by the Assessment Team, as well as supporting documentation and actions taken in response. The response also included a Training plan, as well as a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* Introduced new auditing tools, audit schedule and processes, with a focus on clinical outcomes.
* Created a training plan and education relating to management of wounds, pain, urinary tract infections and infections has been included.
* Created and/or updated and disseminated Local work instructions to staff to ensure a consistent approach to specific areas of consumers’ clinical care.
* An audit of all wounds and infections is planned, with follow-up with individual staff where gaps are identified.

I acknowledge the provider’s response. However, I find the workforce was not sufficiently competent or had the qualifications and knowledge to effectively perform their roles.

In coming to my finding, I have considered while management and clinical staff described ways in which staff competence is monitored, these monitoring processes have not been effective in identifying deficits in staff skills and knowledge. Outcomes for consumers highlighted in Standard 3 indicate staff skills and knowledge are not adequate to support the delivery of safe and effective personal and clinical care. Evidence presented in Standard 3 requirements (3)(a), (3)(b), (3)(d) and (3)(g), which have been found non-compliant, demonstrate consumers have not been provided care that is tailored to their needs or optimised their health and well-being, high impact or high prevalence risks have been effectively managed, appropriate action has been taken in response to changes in consumers’ condition or appropriate strategies to minimise and/or manage infections and practices to promote appropriate antibiotic use implemented. Deficits have been identified in provision of care relating to management of weight loss, pain, catheter care, wounds, infections and change in consumers’ condition. I have also considered the outcomes highlighted in Standard 2 Ongoing assessment and planning with consumers requirement (3)(e) demonstrates staff are not skilled or competent with undertaking comprehensive review processes, including in response to changes in consumers’ health and well-being.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish efficacy, staff competency and improved consumer outcomes.

For the reasons detailed above, I find requirement (3)(c) in Standard 7 Human resources non-compliant.

**Requirement (3)(d)**

The Assessment Team were not satisfied processes and systems for recruitment and training, have been effective to deliver the outcomes required by these Standards. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Training schedules indicated all 18 clinical staff completed online wound care training and a wound assessment and management toolbox module in December 2022. The toolbox training did not record completion dates for staff listed. Deficits in clinical care were identified by the Assessment Team.
* Training schedules indicate all staff are up-to-date with training and clinical staff have completed training in relation to high risk consumer care and deterioration. However, deficits in practice were identified.
* Management advised completion of toolbox sessions is monitored and records indicate all staff are up-to-date. Handover processes are used to re-enforce staff knowledge from toolbox sessions which occurs on an ad-hoc basis, however, are not documented.
* There is a planned education calendar which includes scheduled online and toolbox sessions, and there is a lot of on-site informal education and mentoring undertaken, however, this is not documented.

The provider’s response included commentary relating to the deficits identified by the Assessment Team, as well as supporting documentation and actions taken in response. The response also included a Training plan, as well as a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to, created a Training plan to address the deficiencies identified in the Assessment Team’s report; created processes to capture ad hoc training; and education provided to staff on wound management, pressure area care and the deteriorating resident.

I acknowledge the provider’s response. However, I find the service did not adequately demonstrate processes to ensure the workforce is trained, equipped and supported to deliver the outcomes required by these Standards. I have considered that while records and feedback from staff indicates staff have completed training related to wound care, assessment, and management, high risk consumer care and deterioration, the Serious Incident Response Scheme (SIRS) and elder abuse, deficits in relation these aspects of care have been identified with related requirements found non-compliant. I have also considered that while handover processes are used to reinforce staff knowledge from training delivered through toolbox sessions, this is not documented to enable identification of additional training opportunities to further develop staff skills and knowledge.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish efficacy, staff competency and improved consumer outcomes.

For the reasons detailed above, I find requirement (3)(d) in Standard 7 Human resources non-compliant.

**Requirement (3)(e)**

The Assessment Team were not satisfied processes and systems to monitor and review the performance of each member of the workforce have been effective. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Performance appraisals are informed by self-evaluation, feedback and complaints, incident data, on-floor and progress note observations and training feedback.
* Clinical staff and management said they review progress notes daily and take appropriate action to follow up with staff who have outstanding tasks in the electronic care system. Progress notes are also reviewed Monday to Friday. Management said historically, clinical audits were undertaken, however, this was not occurring.
* Management said there is some hesitancy to performance manage clinical staff due to lack of staff availability of this cohort.
* Records indicate staff performance appraisals are up-to-date.
* Management said a staff member had a reputation for being intimidating and erratic towards consumers, however, this was past history and not current and they were not being performance managed. The staff member was suspended during the Site Audit for allegations of neglect.

The provider’s response included commentary relating to the deficits identified by the Assessment Team, as well as supporting documentation and actions taken in response. The response also included a Training plan, as well as a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to, improved care staff performance appraisal documentation; the mentioned staff member is currently being performance managed; and created a Training plan which includes education relating to deficiencies identified in the Assessment Team’s report.

I acknowledge the provider’s response. However, I find ongoing monitoring of the performance of each member of the workforce was not demonstrated.

In coming to my finding, I have considered that while management and clinical staff described ways in which staff performance is monitored, issues identified by the Assessment Team highlighted in Standard 2 Ongoing assessment and planning with consumers and Standard 3 Personal care and clinical care have not been identified. I have also considered feedback from management who stated there was a hesitancy to performance manage clinical staff due to a lack staff availability in this cohort. As such, I find the evidence presented indicates the service’s ongoing monitoring of the workforce’s duties, responsibilities and performance is not effective to ensure the workforces’ overall ability to provide consumers with quality care and services.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish efficacy, staff competency and improved consumer outcomes.

For the reasons detailed above, I find requirement (3)(e) in Standard 7 Human resources non-compliant.

**In relation to requirements (3)(a) and (3)(b),** the service has processes to ensure the workforce is planned and the number and skills mix enables the delivery of quality care and services. Staffing levels and mix are monitored through review of feedback and complaints data, call bell response times and direct observations of staff practice. Staff were generally satisfied they had sufficient time to undertake tasks, however, two staff indicated when unplanned absences occur, or when care staff are moved to other roles, shifts are not backfilled, and staff have less time to spend with consumers. Overall, consumers felt there were enough staff to meet their needs, however, some consumers and representatives said staff turnover impacts consistency of care, and when staff are busy, representatives indicated they are not always informed of incidents in a timely manner.

Consumers and representatives said staff are kind, caring and respectful in their interactions and treat consumers well. They also indicated staff know consumers’ likes and dislikes which are catered for. Staff were knowledgeable about consumers’ identity, culture and diversity and could describe how they deliver person-centred care.

For the reasons detailed above, I find requirements (3)(a) and (3)(b) in Standard 7 Human resources compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Non-compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Non-compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Non-compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Non-compliant |

Findings

The Quality Standard is assessed as non-compliant as four of the five specific requirements have been assessed as non-compliant. The Assessment Team recommended requirements (3)(b), (3)(c), (3)(d) and (3)(e) in Standard 8 Organisational governance not met.

**Requirement (3)(b)**

The Assessment Team were not satisfied the organisation’s governing body is provided with sufficient information to enable them to determine whether care provided is safe and effective. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Management advised that although there is an annual audit schedule which includes clinical and non-clinical audits, audits undertaken are not fit for purpose, are more focused on policy review and do not require staff undertaking the audit to review consumer data and files to ensure policy and/or Local work instructions are followed, and risks associated with consumer care identified in a timely manner.
* Deficiencies in relation to management of wounds, pain and infection related risks were not identified by clinical monitoring processes and information provided to the Board was not presented in a format to alert them to deficiencies in practice, related risks and outcomes to consumer care.
* There is no wound audit and although total number of wounds is reported on a monthly basis to the Quality and Governance Committee, insufficient information is included to alert the Committee to wounds which are not identified, treated in accordance with wound management plans, healing within agreed treatment goal timeframes, or referred to wound care experts or Medical officers.
* Management said although the Board is informed about the number of SIRS incidents and provided with a brief description, these are not always discussed in detail as they are considered more operational, and the Board is more strategic. Review of incidents is by internal audits, feedback, calls from the Commission and discussions with managerial staff and are not discussed at Quality and Governance Committee meetings.
* A Board member sits on the Quality and Governance Committee and are a conduit to the Board in identifying and highlighting risk. Meeting minutes indicate information is provided in relation to falls, behaviours, wounds, infections, medications and transfer to hospital. However, information presented is summarised data and management acknowledged this does not include trend analysis, risk identification or mitigation strategies related to consumer care.

The provider’s response included commentary relating to the deficits identified by the Assessment Team, as well as supporting documentation and actions taken in response. The response also included a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* Amended Quality and Governance Committee meeting minutes to ensure information presented at the meeting is captured.
* Revised the Board report for the Service manager to provide an overview of risks and include clinical governance, human resources, consumer advisory and Quality and Governance.
* Updated the directory of management meetings work instructions to include specific documents used to communicate current risk states of services, responsibilities of specific governing committees in reporting to the Board and communication back from the Board.

I acknowledge the provider’s response. However, I find the organisation did not effectively demonstrate the governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

In coming to my finding, I have considered that reporting processes from a service and organisational level to the governing body are not sufficient to ensure the governing body is aware of and accountable for the delivery of care and services.

While information related to a range of clinical indicators is discussed at organisational meeting forums, data presented is summarised and does not include trend analysis, risk identification or mitigation strategies related to consumer care. Additionally, the service’s own monitoring processes, including audits, have not been effective in identifying deficiencies in clinical care, therefore, not ensuring accurate data is presented and considered at an organisational and Board level. I find deficits in reporting have not ensured the governing body has sufficient oversight of the service’s performance to enable improvements to the quality of care and services to be identified. Systemic issues have been found in relation to provision of clinical and personal care and human resource management. I have considered such practices do not ensure the governing body is aware of whether it is meeting what consumers, the workforce and others expect for safe, inclusive and quality care and services from the organisation.

I have also considered that the findings of non-compliance in relation to 13 requirements across four of the eight Quality Standards indicates the governing body may not sufficiently understand their responsibilities as they relate to monitoring and improving the performance of the organisation against the Quality Standards.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish and embed processes and improved consumer outcomes.

In relation to auditing tools and processes, I consider the evidence relates to continuous improvement processes. As such, I find the evidence is more aligned with requirement (3)(c) in this Standard and have considered it with my finding for that requirement.

For the reasons detailed above, I find Requirement (3)(b) in Standard 8 Organisational governance non-compliant.

**Requirement (3)(c)**

Effective organisation wide governance systems relating to financial governance, regulatory compliance and feedback and complaints were demonstrated. However, the Assessment Team were not satisfied organisation wide governance systems and processes relating to information management, continuous improvement and workforce governance were effective. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

Information management

* Information management systems and processes were not effective to provide members of the workforce access to information that assists them in their roles and to appropriately analyse and manage risk.
* Medical officer notes are not recorded and clinical staff said they do not know what the Medical officer is doing unless they do rounds with them. Documentation viewed confirmed Medical officer notes are not recorded.
* A clinical handover work instruction outlines the requirement for handovers to have a verbal requirement wherever possible. Care staff reported they no longer do handover to each other at morning shifts. Management said care staff are provided with relevant information from handover processes undertaken by clinical staff.
* Care staff reported they do not have staff meetings and rely on information provided to them by clinical staff or by reviewing care plans. Management said care staff are not paid to attend staff meetings, so attendance is poor.

Continuous improvement

* All opportunities for continuous improvement are not effectively identified through internal mechanisms, such as review of practices and incidents and where issues and risks have been identified, these are not included on the PCI.

Workforce governance

* The service was not able to demonstrate staff were always trained or provided with guidance to equip them with the knowledge to perform in their roles, with systems in place to monitor staff competency and ensure their performance is regularly monitored and reviewed.

In coming to my finding for this requirement, specifically continuous improvement, I have also considered the following evidence, and the provider’s response, highlighted in requirement (3)(b) in this Standard:

* Management advised that although there is an annual audit schedule which includes clinical and non-clinical audits, audits undertaken are not fit for purpose, are more focused on policy review and do not require staff undertaking the audit to review consumer data and files to ensure policy and/or Local work instructions are followed, and risks associated with consumer care identified in a timely manner.

The provider’s response included commentary relating to the deficits identified by the Assessment Team, as well as supporting documentation and actions taken in response. The response also included a Training plan, as well as a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* Reminders to care staff of documented handover tools to ensure consistency of care.
* Medical officer log-in details reissued and Registered nurses given access to the electronic system to enable Medical officer passwords to be reset, if required.
* Updated the clinical handover tool and reviewed and updated related Local work instructions.
* Introduced new audit tools and created and audit schedule and processes.
* Care staff meeting held and additional meetings added to the schedule.
* Updated the PCI to include all opportunities for continuous improvement.
* Education relating to the content of specific Local work instructions added to the training schedule.

I acknowledge the provider’s response. However, I find effective organisational governance systems, specifically in relation to information management, continuous improvement and workforce governance were not demonstrated.

I find that information used by staff to guide provision of care and services was not available or up-to-date. Information in care plans sampled was either not up-to-date or reflective of consumers’ current care needs and preferences or did not include sufficient information relating to management strategies to guide staff with provision of consumers’ care and services. I have also considered care staff meetings are not consistently held; handover processes to care staff between shifts are not effective; and Medical officers do not consistently document in care files following review of consumers. I find such practices do not ensure sufficient exchange of information relating to consumers’ care and services. Furthermore, data, including in relation to infections and clinical incidents, is not being effectively collected to enable accurate trending, analysis and reporting to occur or improvements in the provision of care and services to be identified at an individual, site or organisational level.

I acknowledge a PCI is maintained and tabled at relevant meetings for review and approval. However, audit tools are not fit for purpose, focussing on policy, rather than consideration of consumer care files and care and service provision, and while other avenues to identify improvements, such as data collection related to infections and clinical incidents are undertaken, data presented in meeting minutes is not analysed for trends to enable improvement opportunities at both a service and organisational level to be effectively identified. Furthermore, I have considered the findings of non-compliance in relation to 13 requirements across four of the eight Standards indicates deficiencies with the governance processes associated with continuous improvement.

In relation to workforce governance, I have considered that evidence provided in the Assessment Team’s report in relation to Standard 7 demonstrates the organisation’s workforce governance systems are not effective. Three of the five requirements in Standard 7 have been found non-compliant. I find the organisation’s processes have not ensured the workforce is competent, or supported to deliver safe and quality care and services to consumers. I have also considered deficits highlighted across four of the eight Quality Standards indicates the organisation’s processes to monitor and review the performance of each member of the workforce have not been effective.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish and embed processes, staff competency and improved consumer outcomes.

For the reasons detailed above, I find Requirement (3)(c) in Standard 8 Organisational governance non-compliant.

**Requirement (3)(d)**

The Assessment Team were not satisfied effective risk management systems and practices relating to high impact or high prevalence risks, identifying and responding to abuse and neglect, and management and prevention of incidents were demonstrated. The Assessment Team’s report did not specifically reference systems and practices to support consumers to live the best life they can under this requirement. However, I have relied upon evidence highlighted in other Standards and requirements, specifically Standard 1 Consumer dignity and choice requirement (3)(d) which demonstrates effective processes are in place to support consumers to live their best life. The Assessment Team’s report provided the following evidence gathered through interviews, observations and documentation relevant to my finding:

Managing high impact or high prevalence risks

* Policies and Local work instructions available to guide staff in managing deterioration, skin integrity and skin tears, wound care, reporting and documenting clinical incidents and pain management, were not consistently followed and monitoring and/or follow up by the service has not been established to ensure escalation occurs.
* There is a range of clinical and non-clinical audits which are part of an annual schedule. However, management said audits are not effective, as they are broad, focus on what the policy is for and do include a review of consumer information to determine if Local work instructions are being followed.
* As demonstrated in Standard 2 requirement (3)(e) and Standard 3 requirements (3)(a), (3)(b) and (3)(d), identification and management of deterioration, wounds and pain was not effectively demonstrated. Clinical staff did not identify deficits in pain assessments, recognise and respond to deterioration, undertake wound management in line with Local work instructions, including referral to the appropriate health professionals, or complete clinical documentation to facilitate clinical oversight.

Identifying and responding to abuse and neglect of consumers

* Although the organisation has a Minimising potential harm policy outlining a range of practices and processes to reduce likelihood of potential harm related to specific areas of care, this was not consistently effective to identify risks associated with care for specific consumers. High risk consumer meetings are conducted to discuss consumers with complex health needs, incidents of concern and change of health status. However high risk consumers are not always identified and discussed in relation to hospital admissions and discharge and Local work instructions are not always followed or identified through monitoring processes.
* Effective monitoring of consumers who have ongoing infections was not demonstrated. Several consumers have had several courses of antibiotics which has not been identified or discussed in clinical documentation or alternative antibiotics trialled.
* Systems to provide protections and safeguards for consumers were not effective in identifying and responding to the neglect of Consumer B’s wounds, pain and infection. Documentation shows the service failed to identify and respond to Consumer B’s wounds and manage pain or escalate to the appropriate health professional for advice and support in line with Local work instructions.

Managing and preventing incidents

Insufficient information is recorded to enable incidents to be identified and responded to, to improve quality of care and services. Information provided to the Quality and Governance Committee includes data related to incidents, such as falls, near misses, behaviours, wounds medications, hospital transfers and weight. However, an analysis of data presented or trends identified is not included.

* + Falls data does not identify whether falls and near misses relate to recurrent fallers, include identification of reasons for falls or risk mitigation strategies.
  + Wound data does not identify if wounds have been recurrent, long-standing, nor at what stage they were identified and infections do not capture if these are long-standing or if antibiotics have been commenced and effective.

In coming to my finding for this requirement, I have also considered the following evidence, and the provider’s response, highlighted in Standard 7 requirement (3)(c):

* Management acknowledged wound audits have not been undertaken and the current range of scheduled audits are predominantly focused on policy and do not include review of consumer files to ensure staff compliance with work instructions, precluding opportunities to identify deficits in knowledge and implementation of relevant training.
* Wound care is incorporated in the Assessment and care planning audit which was undertaken in October 2022 and includes positive responses.

The provider’s response included actions taken and/or planned in response to the deficits identified by the Assessment Team, as well as supporting documentation. The response also included a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified and a Training plan. The provider’s response included, but was not limited to:

* Updated the Risk management tool which is escalated to the Board monthly.
* Introduced risk into the Clinical meetings and use the electronic system to disseminate information to all staff.
* Ongoing assessment of SIRS and sentinel events for any life-threatening incidents. A Skin care and wound care and Pressure injury prevention audit competed for all consumers, an action plan created and issues identified added to the PCI.

I acknowledge the provider’s response. However, I find the organisation did not demonstrate effective risk management systems and practices in relation to managing high impact or high prevalence risks, identifying abuse and neglect or managing and preventing incidents.

In coming to my finding, I have considered the service has not demonstrated effective risk management systems and practices to support management of consumers’ clinical care needs and high impact or high prevalence risks, specifically in relation to catheter care, wounds, pain, deterioration and weight management as highlighted in Standard 3 Personal care and clinical care requirements (3)(b) and (3)(d). While three consumers highlighted have been identified with clinical care needs and/or high impact or high prevalence risks, these have not been effectively managed and/or monitored, to ensure timely identification, assessment and monitoring of risks to their health, safety and well-being. I have also considered that the organisation’s own monitoring processes, including audit processes, have not identified deficits identified by the Assessment Team relating to management of high impact or high prevalence risks to consumers’ care.

In relation to managing and preventing incidents, I have considered insufficient information is captured to enable incidents to be identified and effectively responded to. Additionally, incident data is not analysed to assist to identify trends and opportunities for improvement or to ensure risks to consumers’ health and well-being are minimised and/or eliminated.

In relation to identifying and responding to abuse and neglect, I have considered systems to provide protections and safeguards, specifically in relation to Consumer B, were not effective in identifying, monitoring and responding to issues relating to wounds, pain and infections.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish and embed processes, staff competency and improved consumer outcomes.

In relation to infections and antibiotic use, I consider the evidence relates to antimicrobial stewardship. As such, I find the evidence is more aligned with requirement (3)(e) in this Standard and have considered it with my finding for that requirement.

For the reasons detailed above, I find Requirement (3)(d) in Standard 8 Organisational governance non-compliant.

**Requirement (3)(e)**

The Assessment Team were not satisfied an effective clinical governance framework, inclusive of antimicrobial stewardship and minimising use of restraint was demonstrated. The Assessment Team’s report did not specifically reference open disclosure under this requirement. However, I have relied upon evidence highlighted in other Standards and requirements, specifically Standard 6 Feedback and complaints requirement (3)(c) which demonstrates open disclosure principles are applied when things go wrong. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

Antimicrobial stewardship

* Infections and/or wounds are not consistently identified, categorised correctly, monitored and/or reported by staff.
* Management said they are trying to work with the Medical officers who have been ‘trigger happy’ at providing antibiotics.
* The Local work instruction outlines a number of audits to be completed related to antimicrobial stewardship, however, these have not identified antibiotics being prescribed without pathology reports for all consumers.
* Although clinical staff demonstrated knowledge about reduced effectiveness of antibiotics for more than two courses, documentation indicates some consumers have had more than two courses of antibiotics, progress notes do not document they have been reviewed for effectiveness and they do not evidence alternative strategies used as required by the Local work instruction.
* Clinical monitoring processes, such as high risk consumer, Resident of the day and Medication Advisory Committee meetings have not been effective in identifying multiple use of antibiotics or ongoing use of antibiotics for some consumers.

Restrictive practices

* Management reported restrictive practices are reviewed monthly, however, no documented audit is conducted, and audit tools being utilised by the organisation are being reviewed.
* Management stated consumers have access to codes for pin-code operated doors. On two occasions, doors were locked. Some staff said these doors are often locked, however, management said they were locked due to a fire drill.

In coming to my finding for this requirement, I have also considered the following evidence, and the provider’s response, highlighted in Standard 3 requirement (3)(g):

* Management stated all consumers who are prescribed antibiotics for infections are captured in the Infection register, however, this was not evidenced in documentation reviewed

The provider’s response included actions taken and/or planned in response to the deficits identified by the Assessment Team, as well as supporting documentation. The response also included a Training plan and a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to, introduced new auditing tools, audit schedule and processes, with a focus on clinical outcomes; reviewed and updated related Local work instructions; and planned training related to antimicrobial stewardship and restrictive practices to be completed by April 2023.

I acknowledge the provider’s response. However, I find the organisation’s clinical governance framework was not effective. While I find effective systems were demonstrated in relation to open disclosure and restrictive practices, I consider systems relating to antimicrobial stewardship are not effective.

I have considered that while an Infection register is available, the register was found not to include all consumers identified with an infection and prescribed antibiotics. As such, the data collected through the register is not accurate making monitoring of infection rates and antimicrobial use difficult. I find this has not ensured an effective system to prevent, manage and control infections and antimicrobial resistance is maintained to assist to identify trends and opportunities to improve the care and services delivered. I have also considered pathology testing prior to commencement of antimicrobials is not routinely undertaken. I find such processes do not ensure effective prevention, management or control of infections and antimicrobial resistance or that antimicrobials are prescribed in line with best practice guidelines.

I have also considered the findings of non-compliance in one of the five requirements in Standard 2 Ongoing assessment and planning with consumers and five of seven requirements in Standard 3 Personal care and clinical care. The findings in these Standards and the evidence presented in this requirement indicates the organisation’s clinical governance framework is not effective, with deficits highlighted not being identified by the service’s or organisation’s own monitoring processes.

I have considered the evidence presented does not demonstrate systemic deficits with the clinical governance framework as it relates to minimising the use of restraint. While there are no audit tools related restrictive practices, the Assessment Team’s report indicates use of restrictive practices is monitored and reviewed on a monthly basis. Standard 3 Personal care and clinical care does not include any reference or deficits relating to restrictive practice use for individual consumers.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish and embed processes, staff competency and improved consumer outcomes.

For the reasons detailed above, I find Requirement (3)(e) in Standard 8 Organisational governance non-compliant.

**In relation to requirement (3)(a),** consumers are engaged in the development, delivery and evaluation of care and services through care planning meetings, feedback processes, surveys and consumer meeting forums. A Consumer Advisory Committee is being established to create links between consumers and the Board, and one consumer spoke of their involvement in the development and implementation of this initiative. Consumers and representatives sampled said they provide feedback in relation to care and services, including at meetings and through ongoing discussions with staff which influence the services consumers receive.

For the reasons detailed above, I find requirement (3)(a) in Standard 8 Organisational governance compliant.

1. The preparation of the performance report is in accordance with section 40A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)